DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI : RE & MEDICAID SERVICES

FRINTED: 05/07/2008 FORM APPROVED

CIMB NO. 0936-0391

	FOF DEFICIENCIE OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) M A. BU		<b>∤</b>	3) Date Sl Comple	
			09G159	a. Wi	اG_		04/2	5/2008
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W 114	24, 2008, three fundamental of three client population of and other disbased on obstwo day progracords, inclu 483,410(c)(4). Any individual record must in the findings of the fundamental client #1 she had a tiny incident report client #1 did medications to administered investigative #2008 incident signature of tilent #1 signature of tilent #1 signature of tilent #2008 incident report client #1 did medications to administered investigative #2008 incident signature of tilent #1 signature si	n suive; sive fit in the against the again	rvey was conducted from April April 25, 2008 using the y process. A random sample is selected from a residential emales with mental retardation es. The survey findings were ons in the group home and at interviews and a review of anusual incident reports. ENT RECORDS makes an entry in a client's it legibly, date it, and sign it.  Is not met as evidenced by: and record review, the facility it each client's records were tree clients (Client #1) in the conduction of the conductio	W		GOVERNMENT OF THE DISTR DEPARTMENT OF H HEALTH REGULATION AD 825 NORTH CAPITOL ST., N WASHINGTON, D.C.	ict of collection of collectio	IOMBIA ION IOOR
Maurel		المالانين. - الداورين		MATURE		TITLE		(X8) DATE
	v statement endin	1 With	20 actorick (5) denotes a deficiency whi	- L - N -	ele "	Director of Disability Eve		5/16/08

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient; protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey with their or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these discuments are made available to the facility. If deficiencies are cited, an approved plan of correction is it quisite to continued

FORM CM8-2867(02-99) Previous \ arsions Obsolete

Event ID: VD1P11

Facility ID: 09G158

If continuation sheet Page 1 of 24

DEPARTMENT OF HI ALTH AND HUMAN SERVICES CENTERS FOR MEDICAID SERVICES

F'RINTED: 05/07/2008 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIE OF CORRECTION	;	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION IG	():3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUF	PLIER		STREET ADDRESS, CITY, SYAYE, ZIP CODE 6613 6TH STREET, NW WASHINGTON, DC 20012				
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W 114	Coordinator's of the invest! 2008 incident signature of it. Coordinator's Interview with PM revealed were forward Management Although the investigations was no docur	(IMC) ative also fine included the Coordina QN were nented to the CO to the QN were nented to the CO t	review. Additionally, review summary for the October 14, alled to evidence the date and dent Management	W	1114			
	25, 2008 at 3 Management Continued re- no document by the facility #1's record re- Assessment" evidence the Retardation F	29 PM Care I iew of d evid riursi vealed daited dignati ofess	#1's medical book on April 1 revealed a Health Plan dated April 14, 2008, if the plan revealed there was dence that it had been signed a. Further review of Client I a "Community & Home Life May 23, 2007 also falled to ure of the Qualified Mental Ional (QMRP).			2. The QMRP will sign each Communit Assessment, and the Nurse will sign each Care Management Plan to indicate that the been reviewed.	h -lealth	6/Kolo8
W 120	designated lina a signature a	e lat th d date SERV	ICES PROVIDED WITH	<b>W</b> 1	20			
		ısi asş	sure that outside services			The QMRP will inform the Day Program that the client needs to have an individual behavior support plan developed to support needs while she is present there. The QM is a present the plant of the probability of the probabil	ized or her EP will	
	This STANDA Based on obs	₹I) is ≥n/atic	not met as evidenced by: on, interview and record			include language in the letter requesting t staff be trained in using and documenting behavior support plan.	brá day tire	6/16/08

FORM CMS-2567(D2-99) Previous \ arelone Obsoleta

Event ID: VD1P11

Facility ID: 09Q159

If continuation sheet Page 2 of 24

DEPARTMENT OF HE ALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FRINTED: 05/07/2008 FORM APPROVED CMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED			
		09@159	B. WING	<del></del>	04/2	5/2008			
NAME OF P	ROVIDER OR SUF	ı⊔≛R	STREET ADDRESS, CITY. STATE, ZIP CODE 6813 6TH STREET, NW WASHINGTON, DC 20012						
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W 120	review, the far services met (Client #2) in The findings of th	्रों.ty failed to ensure that outside he needs of one of the three clients skided in the sample.	W 12	0					
	At 11:46 AM, head and sha making soft v member agai also asked th drink. The strof water but the refused to state staff asked C. The client refinember was puzzle while a speech pathol and assisted	havior.  Client #2 was observed to rub her ke her head up and down, while arbal sounds. At 11:47 AM, the staff is asked Client #2 to stand up and a client if she wanted something to iff member offered Client #2 a cup is client refused the water and incl. At 11:52 AM and 11:54 AM, ient #2 to please stand up again. Ised. At 11:56 AM, the staff observed to engage the client with a eatled at the sofa. At 12:00 PM, the oglist came into the treatment room he client off of the sofa with the help at Program Plan (IPP) coordinator.							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F'RINTED: 05/07/2008 FORM APPROVED

			A MEDICAID SERVICES			CIMB NO	<u> 020-8880 .C</u>
AND PLAN	T OF DEFICIENCIE OF CORRECTION	, î	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	L CONSTRUCTION DING	(7.5) DATE COMP	SURVEY LETED
		· <del></del>	09G159	B. WING	S	04/	25/2008
CARECO	PROVIDER OR SUF	' ºLIER		;	STREET ADDRESS, CITY, STATE, ZI 6613 6TH STREET, NW		20/2000
(X4) ID PREFIX TAG			TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOUL) BE THE APPROFRIATE	(X5) COMPLETION DATE
	At 12:01, Clic. in completing 12:04 PM, the table to s. At 12:05 PM, grabbed the son her head, her to come I to go back to was observed 12:34 PM, the face. At 12:3 her hands in fingers. The intermittently while puckern the back of his linear had 2008. Upon I revealed that plan. The expin plemented the residential approximately developed to behaviors of I pulling and report Continued interport and continued inte	nt #2 if the property of the property of the property of the solient of the property of the resolient of the property of the p	was observed to be engaged uzzle while at the table. At t was observed to move from on the sofa.  #2 came to the surveyor and or's hand in order to place it told the client "no" and asked to the table, but the client opted fa. At 12:20 PM, Client #2 ng the back of her head. At twas observed rubbing her the client was observed with finer face while moving her was also observed to her mouth from side to side lips, shake her head and rub directed with the IPP coordinator 12:10 PM to ascertain if avior Support Plan (BSP). It coordinator, the day but it expired on January 28, of the expired plan, it was sidential provider developed an was designed to be residential facility. Review of the client with reducing target we scalp rubbing and hair	W 12		JT)	

If continuation sheet Page 4 of 24

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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			09G159	B. WII	NG		04/:	25/2008
NAME OF P	ROMDER OR SUF	YUER				EET ADDRESS, CITY, STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·
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W 120	Continued Fr	בק וחנ	ge 4	w	120			<u> </u>
W 124	residential pliday program on April 25, 2 plan had not room. It showith the class new to the de 2008. At the to ensure Cliconsistently respectively and the facility management (if the of the client's	n was Inter 108 at teen i Id be room y progime on #2' tanag PRO ast en facilitatient medicalistatient medicalistatient in the International In	erapist revealed that the so not being implemented at the view with the classroom staff to 12:20 PM verified that the implemented in the treatment noted that additional interview staff revealed Client #2 was gram and began on January 2. If the survey, the facility failed is behaviors were being ed while at the day program. TECTION OF CLIENTS asure the rights of all clients by must inform each client, is a minor), or legal guardian, call condition, developmental	W·	124			
	This STAND/Based on intefailed to ensu their legal gurmedical condistatus, attend to refuse trea (Clients #2 ar The findings informed con	RD is view e the rdian fice, e ant ris ment, d #3) relude ed to ent wal guar	provide evidence that as obtained from each client ordian for the use of their					

FORM CMS-2567(02-99) Previous 's entions Obsolets

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Facility (D: 09G159

If continuation sheet Page 5 of 24

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

'RINTED: 05/07/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(3) DATE SURVEY COMPLETED	
		•	09G159	B. WI	NG_		DAL	7£/2000
CARECC	PROVIDER OR SUI	PLIER			6	REST ADDRESS. CITY, STATE, ZIP CODE 613 61H STREET, NW VASHINGTON, DC 20012	1 04/.	25/2008
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	administration 4:48 PM revoluting Clohaurse during revealed the used to addrive used to addrive consent for the habilitation so verified on Alteview of Clie dated June 3 assessment, capacity to make behalf regard placement, the matters due 1 can not execution to the continued into 2008, further a legal guardial April 28, 2008 however, the that informed #2 and/or a legal guardial the use of heir continued into 2008 further a legal guardial April 28, 2008 however, the that informed #2 and/or a legal guardial the use of heir continued into 2008 further and/or a legal guardial that informed #2 and/or a legal guardial that informed #4 and/or a legal	on of the one o	ne evening medication pril 24, 2008 at approximately lient #2 received medications Interview with the medication adication administration rentioned medication was client's behaviors.  esidential Director (RD) on 8 AM revealed that Client #2 racity to give informed of her medications and The RD's statement was 2008 at 4:37 PM through psychological assessment According to the #2 "does not evidence the dependent decisions on her habilitation planning, at, financial and medical und mental retardation. She urable power of attorney." with the RD on April 24, and that Client #2 did not have be RD revealed that Client #2 the time of the survey failed to provide evidence at was obtained from Client uthorized representative for ptropic medications.  The evening medication and the survey failed to provide evidence at was obtained from Client uthorized representative for ptropic medications.  The evening medication and the survey failed to provide evidence at was obtained from Client uthorized representative for ptropic medication and the survey failed to provide evidence at was obtained from Client atthorized representative for ptropic medication and the survey failed to provide evidence at was obtained from Client atthorized representative for ptropic medication and the survey failed to provide evidence atthorized representative for atthorized representative for atthorized representative for atthorized representative atthorized repres	W		1. Client #2's guardian will be provided written information on her medical treat and the QMRP will request the guardian written consent for the treatments.  2. Client #3's sister is her medical decision A package with information on her medit treatments will be provided to her, and the	on maker.	
	including Clor : Abilify. Interd during the me :	izepar iew wi lication	n, Clonidine, Paroxetine and th the medication nurse administration revealed the ications were used to			will request her written consent for such	treatments.	6/16/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES PRINTED: 05/07/2008 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIE OF CORRECTION	3	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MI A, BUIL	ULTIPLE CONSTRUCTION		E SURVEY PLETED
			09 <b>G1</b> 59	B' MIN	G		4/25/2008
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	April 22, 200: did not have consent for ti habilitation so verified on Apreview of Clied dated June 3 assessment, capacity to misher regard placement, to matters due: Continued int 2008, further a legal guard however, the that informed #3 and/or a legal guard h	the life at 8 the case vices in #300 Client at most reveal at the case of the	Residential Director (RD) on 48 AM revealed that Client #3 specify to give informed a of her medications and s. The RD's statement was 2008 at 7:23 PM through s psychological assessment 07. According to the transition of the survey of the time of the client.	W 1			
- '	The findings i	ıç:ud:	in the sample.  cident reports on April 24,	-	follow the policy t	lensure that staff who do not for notifications receive both ciplinary action if appropriate.	6/16/08

FORM CMS-2567(02-09) Previous 1 ersions Obsolete

Event ID: VD1P11

Facility ID: 09G159

If continuition sheet Page 7 of 24

DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING			(X I) DATE SURVEY COMPLETED	
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W 149	Client #1 data incident report counselor that finger. Reviet dated March the previous indicated that hand. Further Summary" remade for dist failing to common the supervisor laterview with April 24, 200% employee was incident report their shift. Correvealed if the and the client care, the mer client upon her shift on Aproperson who wan incident shadditionally, responsible finurse, the Quantices.  At the time of provide evide	AM I de Madicial d	revealed an incident involving such 25, 2008. According to the ent #1 reported to her 1:1 had a tiny cut on her left he "Incident Summary Report" 2008 revealed that staff on dutying (March 24, 2008) had at #1 had a slight injury to her ew of the "Incident Report d a recommendation was any action to the 1:1 staff for an incident report or notifying r to the end of his shift.  Residential Director (RD) on 13 PM revealed that each consible for filling out an questionnaire before leaving ed interview with the RD dent was a reportable incident not need immediate medical on nurse would examine the	W				

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NAME OF F	PROVIDER OR SUF	PLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW WASHINGTON, DC 20012					
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W 149	Continued Fi 2. On Octobe involving Clie receive her p scheduled to dosage." Co revealed an i Qualified Mei (QMRP). Th that the inves Interview with PM revealed were forward Management Although the investigations was no docur investigation	r 14, 2 nt #1 i iycholoei ad itinue ivipstig tal Reirei waigatio the Chart the dot to the Qli were ienter	W	149	2. The IMC will sign each incident repoinvestigation to indicate that she has revithem.	r and/or	6/16/08	
W 153	policy on Aprilinvestigation the RDs/QMF At the time of provide evide management implemented 483.420(d)(2) CLIENTS The facility ministreatment, injuries of unkimmediately to	25, 2 of repo Pro wi the su rep th sclicy is out STAF  st en neigle newn the s	Sure that all allegations of ect or abuse, as well as source, are reported administrator or to other ce with State law through	<b>W</b> 1	153	The QMRP will ensure that the RD and s retrained on the incident management and policy and protocol, and specifically the preporting incidents to the administrator an officials, among others.	iseporting	6/16/08

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/07/2008 FORM APPROVED

STATEME	ELIZOT ON MEE		& MEDICAID SERVICES		<u> </u>	OMB NO	0. 0938-039
AND PLAN	NT OF DEFICIENCI NOF CORRECTION	S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE : COMPL	SURVEY
			09 <b>G15</b> 9	B. WNG_			
NAME OF	PROVIDER OR SU	'Pl.IER		STE	REET ADDRESS, CITY, STATE, ZIP CODE	04/:	25/2008
CARE				6	613 6TH STREET, NW VASHINGTON, DC 20012		
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	This STAND Based on int. failed to ensi injurious of use reported to the accordance clients (Clientacility.  The finding in the facility's investigative at 9:45 AM a 2:44 PM reverse a. On July 3, revealed she report indicated review of the evidence that immediately to officials in accordance with State law.  At the time of provide evide inclination of the time of provide evide in the time of provide evide evide in the time of provide evide e	AFID is arrisew that aknowing administration with States and the factories incidents and on Analysis the incidents and the administration of the administration of the survival and the administration of the survival and the administration of the administration of the survival and the administration of the ad	and met as evidenced by: and record review, the facility all allegations of abuse and a source were immediately inistrator or to other officials in the law, for two of the five d #5) that resided in the  cility's Qualified Mental onal (QMRP) and review of a reports and corresponding on April 24, 2008, beginning pril 25, 2008 beginning at a following:  citaff reported that Client #3 shed by Client #2. The the client fell. Continued incidents failed to provide ident was reported iministrator or to other a with State law.  Or staff reported observing marks on the lower part of review of the facility's vide evidence that the immediately to the are officials in accordance	W 153	DEFICIENCY)		
	omer omeials i aforemention:	vare im d incide	mediately notified of the ents as required. TREATMENT OF	W 154	•		

FORM CMS-2587(02-99) Provious \ 25 lone Obcolete

Event ID: VD1P11

Facility ID: 09G159

If continuation sheet Page 10 of 24

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PRINTED: 05/07/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED <u>CENTERS FOR MED CARE & MEDICAID SERVICES</u> OMB NO. 0938-0391 STATEMENT OF DEFICIENCIT'S AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G159 04/25/2008 NAME OF PROVIDER OR SUI FLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6613 BTH STREET, NW CARECO 02 WASHINGTON, DC 20012 SUMM, RY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEI CIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATO LY OR LEC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY W 154 Continued From page 10 W 154 CLIENTS The Director of Disability Services will on ure that The facility in usit have evidence that all alleged the OMRP and staff are retrained on facilit? violations are thoroughly investigated. incident management policies, including reporting, 6/16/08 investigating, and review with all involved people. This STAND (RD is not met as evidenced by: Based on intriview and record review, the facility failed to ensure that all allegations of abuse and injuries of un thawn origin were thoroughly investigated, for three of the five clients (Clients #2, #3, and # 5) that resided in the facility. The findings helude: Interview with the facility's Qualified Mental Retardation Frofessional (QMRP) and review of the facility's it circlents reports and corresponding investigative reports on April 24, 2008, beginning at 9.45 AM and on April 25, 2008 beginning at 2:44 PM revealed the following: a. On July 3, 2007, staff reported that Client #3 revealed she was pushed by Client #2. The report indicat: d that the client fell. Continued review of the acility's incidents failed to provide evidence that the incident was investigated. b. On Octob ir 29, 2007 staff reported noticing a bandage on t e back of Client #3's neck. Upon

FORM CMS-2567(02-09) Previous \ :raiona Obsolete

removal of the bandage staff observed an open area. Continued review of the facility's incidents revealed the UMRP completed an investigation for the aforen antioned incident on November 2, 2007. Review of the corresponding investigation revealed another client had "an open area which appears to be similar." There was no indication about the outcome of the correlation between Client #3's injility and that of the other client that

Event (D: VD1F11

Facility ID: 09G159

If continuation sheet Page 11 of 24

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DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI X-RE & MEDICAID SERVICES

FRINTED: 05/07/2008 FORM APPROVED CIMB NO. 0938-0391

STATEMENT OF DEFICIENCIE: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ILDING	PLE CONSTRUCTION	(23) DATE SURVEY COMPLETED	
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W 154	was mention survey, the far interview member that of its investig	d. A sility ras contial ation.	dditionally, at the time of the failed to provide evidence that onducted with the the staff by observed the injury as a part	W	154			
	hand. Review that there was area. There of the correla	r of the case of t	ne investigation report revealed ther client with a "similar" open o indication about the outcome etween Client # 5's injury and ent that was mentioned.				;	
•	a long bruise chest. Contir revealed the	going ueld i lecility	6, 2007, staff reported noticing down the center of Client #2's review of the facility's incidents failed to provide evidence that injury was investigated.					
	#5 was obser lower part of facility's incid	red to Fer no Ints r Ioe ti	2007, staff reported that Client of have a reddish mark on the eck. Continued review of the evenued the facility failed to nat the aforementioned injury					
	Client #2 was review of the facility failed t	scrat Bcillit > pro	2, 2007, staff reported that the ched by Client #5. Continued y's incidents revealed the vide evidence that the ury was investigated.					
	Client #1 did medications s "bed time dos investigative i	ol re ched ige." ige."	2007, the staff reported that ceive her psychotropic uled to be administered for her Review of the facility's failed to evidence an interview d with the medication nurse			,		

F'RINTED: 05/07/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES CMB NO. 0938-0391 STATEMENT OF DEFICIENCIE'. (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION () 3) DATE SURVEY AND FLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 09G159 04/25/2008 NAME OF PROVIDER OR SUF PLIER SYREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW CARECO 02 WASHINGTON, DC 20012 (X4) ID SUMM, RY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) BE CROSS-REFERENCED TO THE APPROFIRIATE (X.5) COMPLETION DATE (EACH DEF CITINGY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATOR YOR LSC IDENTIFYING INFORMATION TAG TAG DEFICIENCY W 154 Continued From page 12 W 154 scheduled to administer the medications on the aforemention ad date as a part of its investigation. W 156 483.420(d)(4 STAFF TREATMENT OF W 156 CLIENTS See responses to W114, W149, W153, and W154. 6/16/08 The results of all investigations must be reported to the administrator or designated representative or to other of cials in accordance with State law within five we king days of the incident, This STAND, RD is not met as evidenced by: Based on interview and record review, the facility failed to ensure required investigations were reviewed by the administrator or designee within five working r ays, for two of the five clients (Clients #3 and #6) that resided in the facility. The finding in cludes: Interview with the Qualified Mental Refardation Professional : QiVIRP) and review of the facility's incidents reports and corresponding investigative reports on Ap il 74, 2008, beginning at 9:45 AM and on April 25, 2008 beginning at 2.44 PM revealed the tallawing, a. On October 29, 2007 staff reported noticing a bandage on tile back of Client #3's neck. Upon removal of the bandage staff observed an open area. Review of the corresponding investigative report reveals 1 that the Qualified Mental

FORM CMS-2567(02-99) Previous \ ereions Obsolete

Retardation P of essional (QMRP) completed the investigation in November 2, 2007. There was no evidence that the results of the investigation were reviewed by the administrator or designee.

b. On October 29, 2007 staff reported discovering a sore/scrape on Client #5's right

Event ID: VD1P11

Facility ID: 09G159

If continuation sheet Page 13 of 24

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: . 05/07/2008 FORM APPROVED ()MB NO. 0938-0391

STATEMENT OF DEFICIENCIE. AND PLAN OF CORRECTION		3	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BÜILDI	IPLE CONSTRUCTION	(:3) DATE SURVEY COMPLETED	
			09G159	B. WING_		04/2	5/2008
CAREC	ROVIDER OR SUI	PLIER			REET ADDRESS, CITY, STATE, ZIP CODE 3613 6TH STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEF	CHENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 156	hand. Contine revealed the for the aforer 2007. There	utid re 2MRP rention was r	view of the facility's incidents completed an investigation ned incident on November 2, so evidence that the results of re reviewed by the	W 156			
	after Client # discovered the arm. Review report reveal investigation after the inck.	i got of at the of the dithat on Novierit).	o), 2007, staff reported that ut of the bathtub, it was client had blood on her right corresponding Investigative the QMRP completed the rember 27, 2007 (seven days There was no evidence that restigation were reviewed by designee.	·			-
,	a scratch und review of the investigation December 18 incident).  At the time of	er Clie acility or the 2007 the su	2007, staff reported noticing nt #5's left eye. Continued s incidents revealed an aforementioned incident on (fourteen days after the		•		
W 159	provide evide aforemention required. 483.430(a) Q	ice the	at the results of the estigations were reviewed as	W 159		• •	
	integrated, cc	วเป๋เทล	reatment program must be ted and monitored by a rdation professional.		·		
	Based on inte	view a	not met as evidenced by: and record review, the facility each client's active treatment				

DEPARTMENT OF FEALTH AND HUMAN SERVICES CENTERS FOR MEI !!CARE & MEDICAID SERVICES

PRINTED: 05/07/2008 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENC		(X1) PROVIDER/SUPPLIER/CLIA				D. <u>09</u> 38-0391	
AND PLAN	OF CORRECTION	,	IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION NG	(X3) DATE	
			09G <b>15</b> B	B. Win	NG_			
NAME OF	PROVIDER OR SI	PPLIER		<del></del>	C.T.		04/	<u> 25/2008</u>
CAREC	O 02			ı	6	REET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW NASHINGTON, DC 20012		
(X4) ID PREFIX TAG	REGULAT	-ILLE-NICY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	I PADE	(X5) COMPLETION DATE
W 159	Continued F	'om pag	ge 14	W 1	50			<del>                                     </del>
	program wa monitored by Professiona	'the Qu	ated, coordinated and ualified Mental Retardation <sup>3</sup> ).		39	·		
	The findings	includé	:					
	client s India received cor	dual Pr	to ensure that as soon as Team (IDT) formulated each ogram Plan (IPP), clients active treatment, consisting ons and services. (See			1. The QMRP will ensure that as soon as formulates the IPP, the IPP will be imple and documented.	the IDT nented	6/16/08
	2. The QMR services met W120)	⊃ failed the nee	i to ensure that outside ds of each client. (See			2. See response to W120.		6/16/68
	Observation administration 5:00 PM reversed medications, cup of water includes and nurse independent.	ogram  of the even Apole aled Cline with The clie the make the dentity to	ensure that each client's self was effectively monitored.  /ening medication ril 24, 2008 at approximately ent #3 assisted the administration of herent was observed to bring a edication room (upon verbal medication cup from the potake her medications.			3. The QMRP will prepare an IPP to furniclient's ability to self medicate. The progbe implemented, documented, and review monthly by the QMRP.		6/16/08
: 1 1 1 1 1	Support Plan interview with urther review at the time of interdisciplina program goals tocumented in	ISP) methe QM of Clien he ISP y team . The g	record on April 25, 2008 at clent had her Individual effing on July 17, 2008. RP on April 25, 2008 and t #3's record revealed that meeting, the recommended several oals identified and included goals to Increase ove her community					

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DEPARTMENT OF FEALTH AND HUMAN SERVICES CENTERS FOR MEI ICARE & MEDICAID SERVICES

PRINTED: 05/07/2008 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENC: OF CORRECTION	<b>:</b> 5	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT A. BUILDI	TIFLE CONSTRUCTION NG	X3) DATE S	
			09G159	B. WING_		045	25/2008
NAME OF P	ROVIDER OR SI.	PUER		ST.	1	V4/23/2003	
(X4) ID PREFIX TAG	(EACH DE	*ICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	n~D BE	(X5) COMPLETIC DATE
	skills, Contito identify a increasing in Additional in 2008 at 6:51 assessment continue with Interview was Residential: approximate exact self-mascertain in the program Director of F Client #3's in exact objecti	il skills, nued re program a shift vinter of dated a docum i her see a condition (Contilles) identicand fave and	ge 15 and increase her cognitive eview of Client #3's ISP failed in that specifically dealt with by to self-medicate.  Client #3's record on April 25, vealed a self-medication July 17, 2007. Review of the mented that Client #3 was to elf-medication program. Lucted with the Director of son April 25, 2008 at PM to ascertain Client #3's on program objective and to an regarding the monitoring of mued interview with the tial Services and review of hiled to provide evidence of the failed to provide evidence that was being monitored by the	W 159			•
W 249	Human Right reviewed/app Clients #2 ar 483.440(d)(d) As soon as the formulated seach client in treatment projections and frequence and frequence continuated frequence and frequence continuated frequ	s Com rcived d #3.   ) PROC ie inter client's ust rec gram c and se y to su;	d to ensure the facility's mitee (HRC) Behavior Supports Plans for See W262] SRAM IMPLEMENTATION  disciplinary team has individual program plan, exive a continuous active consisting of needed evices in sufficient number proof the achievement of the in the individual program	W 249	4. The QMRP will ensure that the Huma Committee reviews and approves the the Supports Plans for clients #2 and #3.	r Rights Behavior	6/16/68

Event ID: VD1P11

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DEPARTMENT OF FEALTH AND HUMAN SERVICES
CENTERS FOR MELICIARE & MEDICAID CERVICES

			A MEDICAID SERVICES			QMB N	<u>0. 0938-039</u>	
STATEMEN' AND PLAN (	T OF DEFICIENC OF CORRECTION	E <b>S</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1	ULTIPLE CONSTRUCTION LDING	(X3) DATE	(X3) DATE SURVEY COMPLETED	
			09G159	B. WIN	le	na	/25/200B	
CARECO				•	STREET ADDRESS, CITY, STA 6613 6TH STREET, NW WASHINGTON, DC 200	TE, ZIP CODE	120 <u>120</u> 05	
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	This STANI Based on in failed to ens active treatr Intervention: #2 and #3) i The finding The facility i formal progrimplementer  1. Review c at 5:23 PM r Support Plai with the Qua Professional further review at the time o interdisciplin objectives in Client #2 will during perso month for the Interview with on April 25, 2	ARD is terview. In each rent send reluded reluding r	s not met as evidenced by: and record review, the facility th client received continuous vices, including needed o of the three clients (Clients in the sample.	W 2	1. The OMRP will ensure	e that programming will b	6/16/08	
i i	2. Review of at 7:28 PM re July 17, 2007 25, 2008 and revealed that nterdiscipling objectives inc	Client # vealed Interventer at the tily team unling t	replemented.  #3's records on April 25, 2008 the client had an ISP dated iew with the QMRP on April review of Client #3's record ime of the ISP meeting, the recommended program he following:		2. The QMRP will ensure implemented and docume specified.	that programming is nted in the frequency	6/16/08	
·	7(02-99) Previous '	euwara O	beolete Event (D: VD1P11	i	Facility ID: 08G159	If continua ion sheat	Page 17 of 24	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR ME LICARE & MEDICAID SERVICES

PRINTED: 05/07/2008 FORM APPROVED OMB NO. 0938-0391

AND PLA	AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			09G159	e, wii	NG			10.5 to	
CARE	F PROVIDER OR S		PPLIER			EET ADDRESS. CITY, STATE, ZIP CODE 313 5TH STREET, NW (ASHINGTON, DC 20012	<u>04/25/2</u> 008		
(X4) II PREFI TAG	X   (EAÇH D	u, =iciiency i	EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL DENTIFYING INFORMATION	JD PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLL) CROSS-REFERENCED TO THE APPRI) DEFICIENCY)	IDEE	COMPLETION DATE	
W 24	9 Continued	l rom pag	e 17	W 2	49				
W 262	Interview wapproximate client's recommendate facility failed was given the aforementic frequency red 483.440(f)(3)  The commitmonitor indivinappropriate	lei on a temonth fill hithe QIV a ly 4;35 P a direveale sprember of the provide sed programmed, signification of the control o	lient #3 will correctly dial a elephone keypad on 80% of or three months.  IRP on April 25, 2008 at M and further review of the ed data was collected for the 2007, October 2007, and e time of the survey, the e evidence that Client #3 inlty to participate with the am objective in the ERAM MONITORING &  I review, approve, and grams designed to manage and other programs that, ommittee, involve risks to ghts.	W 2	52		•		
	failed to ens Support Plai by their Hum The finding in 1. Observate administration 4:48 PM reveleding Clo nurse during revealed the used to addr.	arriew an ire: that C is nad been an Rights icludes: on of the city on April aled Citier icline. In this medicaforements the city is the city in the c	ot met as evidenced by; direcord review, the facility dient #2 and #3's Behavior on reviewed and approved Committee (HRC).  Evening medication 24, 2008 at approximately at #2 received medications berview with the medication administration administration ioned medications were ent's behaviors.		a	The QMRP will place the HRC minutes attendence sign-in sheet in the facility's ] ludights record book.	man	Glado8	
™ CMS+25	67(02-99) Previous	/eralons Obse	idele Event ID: VD1P11	F	ac lity	ID: 09G159 If continui tic	on sheet P	'age 18 of 24	

PRINTED: 05/07/2008 DEPARTMENT OF FEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEI ICARE & MEDICAID SERVICES <u>DMB NO. 0938-0391</u> STATEMENT OF DEFICIENCI IS (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING. 09G159 04/25/2008 NAME OF PROVIDER OR SU P JER STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW CARECO 02 WASHINGTON, DC 20012 SUMI, ARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DE 'ICIENCY MUST BE PRECEDED BY FULL PRFFIY (EACH CORRECTIVE ACTION SHOU, DIBE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 262 Continued F oin page 18 W 262 Review of the facility's Human Rights Committee (HRC) minut as on April 24, 2008 beginning at 2:30 PM revitaled a HRC meeting was scheduled to review Cll in s #2's Behavior Support Plan (BSP), which incorporated the client's psychotropic medications. However, at the time of the survey it a racility falled to provide evidence of the date that the committee met to review/approve Client #2's BSP. Interview with the Qualified Mental Retardation Professional (CIMRP) on April 24, 2008, at 2:35 PM verified triat there was no documented evidence of ; "signature sheat" attached to the HRC meetings. Although the QMRP indicated that all of the residents plans were reviewed in January 200; and again in March 2008, at the time of the survey, the facility failed to provide evidence of vihen its HRC reviewed and approved Client #2's BIIP. Observation of the evening medication 2. See response to #1 above. 6/16/08 administration on April 24, 2008 at approximately 5:00 PM revs aled Client #3 received medications including Clonazepam, Clonidine, Paroxetine and Abilify. Inten ew with the medication nurse during the medicatic a administration revealed the aforemention ad medications were used to address the client's behaviors. Review of the facility's Human Rights Committee (HRC) minutes on April 24, 2006 beginning at 2:30 PM reversed a HRC meeting was scheduled to review Clie its #3's Behavior Support Plan (BSP), which incorporated the client's

FORM CMS-2887(02-99) Previous 1 pre lone Obsolete

psychotropic insidications. However, at the time

of the survey he facility failed to provide evidence of the date that the committee met to

Event ID: VD1P11

Fatility ID: 09G159

If continuation sheet Page 19 of 24

DEPARTMENT OF FEALTH AND HUMAN SERVICES CENTERS FOR MEI ICARE & MEDICAID SERVICES

PRINTED: 05/07/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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W 262	] =	-	ge 19 ent #3's BSP,	W 262	· ·			
	Professional PM verified I evidence of HRC meetin that all of the January 200 time of the sevidence of Client #3's E	(C)MR nat the "sign: ys. Alt resside land e inrey, f then it FF;	rualified Mental Retardation P) on April 24, 2008, at 2:36 re was no documented ature sheet" attached to the hough the QMRP indicated ants plans were reviewed in again in March 2008, at the the facility failed to provide s HRC reviewed and approved	•				
W 263	The committee conducts	:e sho :d cally :edien	OGRAM MONITORING & uld insure that these programs With the written informed t, parents (if the client is a dian.	W 263				
	Based on ob review, the fa committee fa programs we had been ob	ervations desired to the control of	s not met as evidenced by: on, Interview and record specially-constituted ensure that restrictive d only after written consents for two of the three clients icluded in the sample.	·			-	
	administratio 4:48 PM reve including Clo hurse during revealed the	t on of on Ap taled C talene. the me torem	the evening medication or il 24, 2008 at approximately lient #2 received medications. Interview with the medication dication administration entioned medication was client's behaviors.	·	1. See response to W124.		र्धार्ज08	
		<b>-</b>			<u> </u>	!	1	

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PRINTED: 05/07/2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES DMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (K3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G159 04/25/2008 NAME OF PROMDER OR SU IPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 02 6613 6TH STREET, NW WASHINGTON, DC 20012 (X4) ID SUMMINRY STATEMENT OF DEFICIENCIES ľÞ PROVIDER'S PLAN OF CORRECTION (EACH DE IC ENCY MUST BE PRECEDED BY FULL PREFIX (XS) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REPERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY W 263 Continued F orn page 20 W 263 Interview wit I the Residential Director (RD) on April 22, 2003 at 8:48 AM revealed that Client #2 did not have the capacity to give informed consent for the use of her medications and habilitation s arvices. The RD's statement was verified on April 25, 2008 at 4:37 PM through review of Cli.:ni: #2's psychological assessment dated June (0, 2007. According to the assessment Client #2 "does not evidence the capacity to n ake independent decisions on her behalf reganting her habilitation planning, placement, ti satment, financial and medical metters due lo profound mental retardation. She can not execute a durable power of attorney," Continued in erview with the RD on April 24, 2008, further revealed that Client #2 did not have a legal guard an. The RD revealed that Client #2 had a guardl inship hearing next week (week of April 28, 200 I). Further revie v of Client #2's record on April 25, 2008 at approximately 4:40 PM revealed that the client, in addition to taking psychotropic medications, also had a Behavlor Support Plan (dated Janua y 28, 2008) to address her behaviors. At the time of the survey however, the facility failed to provide evidence that consent was obtained for the use of the psychotropic medication and Behavior Support Plan (BSP) that were designe d/conducted to reduce Client #2's behaviors. Observati in of the evening medication. administratio cn April 24, 2008 at approximately 2. See response to W124, 6/16/08 5:00 PM revealed Client #3 received medications including Clohazepam, Clonidine, Paroxetine and Abilify. Interview with the medication nurse during the medication administration revealed the aforemention ad medications were used to

FORM CMS-2567(02-98) Previous L'antions Obsolete

Event ID: VD7F11

Facility ID: 09G159

If continua ion sheet Page 21 of 24

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/07/2008 FORM APPROVED OMB NO. 0938-0391

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NAME OF	PROVIDER OR SU			r——			/25/2008		
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W 263		oin pag	ge 21	W 2	263				
	address the	::llent's	behaviors.	VV 2	203			•	
	Interview with	i the Re	esidential Director (RD) on						
	APFII 22, 200	3 at 8:4	B AM revealed that Client #3						
	dia not USAS	the cac	) acity to give Informed						
	consent for i	1e use	of her medications and					1	
	verified on A	Prices.	The RD's statement was						
	review of Cili	서비 스크, , '마' 샾입'는	2008 at 7:23 PM through psychological assessment						
	dated June :	n, 7007	According to the						
	assessment,	Client #	43 "does not evidence the						
1	capacity to n	ake ind	lependent decisions on hec					1	
	nenan regan	nd her	habilitation planning						
	piacement, ti	≋aitmen	it, financial and medical						
ı	Continued is	o mode	rate mental retardation.						
}	2008, further	ccvoalo Brvi¢W∵	with the RD on April 24, d that Client #3 did not have		1.				
	a legal guard	ait.	o that Chefft #3 dig not have						
	Further revie	v of Clie	ent #3's record on April 25,						
	client in additi	ximate,	ly 7:17 PM revealed that the				•		
	Medications	aleo bad	sking psychotropic d a BSP (dated August 16,						
	2007) to add	ess her	behaviors . At the time of		1				
1	nie zatask Val	waver. 1	the facility failed to previous					Ι.	
] '	evideuce IUS	CORSE	It was obtained for the use of					1	
j	nue hakertóftű t	טוג med	ication and BSP that were						
1 '	qesigned/cor : behavlors,	urcted t	to reduce Client #3's				-	}	
v 368 /	483 <sub>-</sub> 460(k)(1	DRUG	ADMINISTRATION	W 36	18				
						RN Supervisor			
1 1	hat all drugs :	readada ≀utuga	administration must assure inistered in compliance with			RN Supervisor will retrain the con the policy for informing the	- D	1	
t	the physician s	orders	instaled in compliance with			e ate least five days prior to the cations running low.	clier ts'	1.1.1	
٦	This STAND, !	nai OS	of met as evidenced by:					6/16/0	
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PRINTED: 05/07/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MED CARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (<3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING, 09G159 04/25/2008 NAME OF PROVIDER OR SUI PLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6013 6TH STREET, NW CARECO 02 WASHINGTON, DC 20012 SUMM. RY STATEMENT OF DEFICIENCIES (X4) )D JD PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (SACH DE ICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATO IY OR USC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) W 368 Continued From page 22 W 368 administered in compliance with the physician's orders, for all e of three clients (Client #2) included in the sample. The finding is cludes: Observation of the evening medication administration on April 24, 2008 at approximately 4:48 PM rev: alad Client #2 received medications Including Clo ricline. At approximately 4:50 PM the medication hurse was observed to obtain a box from the medication cabinet for Client #2 with a label for Ds brox, "instill 3 drops once daily each ear." The modication nurse informed the surveyor that he was not able to administer Client #2's Debrox recause it was "not available." Continued interview with the medication nurse revealed that the facility's designated nurse was responsible for ordering the client's medications. On the next c ay at 5:29 PM, the medication nurse was interviewed prior to leaving the facility. The medication norse was asked if Client #2's Debrex was ordered and administered. The medication nurse reveals. I again that the ear drops were not available. The facility's designated nurse was present at the time and indicated that she was not aware that Cl and #2's Debrox needed to be refilled, because, at the time of the survey, the medication nurse failed to Inform her. Interview with the designated nurse on April 25, 2008 at 5:33 ! M revealed that it was the responsibility of the medication nurse to inform her at least fix e (5) days before the client's medication runs low. The designated nurse was

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completed for the month.

then overhea: I on the phone ordering Client #2's ear drops, two days after the medication was

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If continuation sheet Page 23 of 24

PRINTED: 05/07/2008 DEPARTMENT OF I EALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR ME ICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENC ES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G159 04/25/2008 NAME OF PROVIDER OR SUPFLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW CARECO 02 WASHINGTON, DC 20012 (X4) ID SUMI AFLY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PRÉFIX (EACH DE FICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH CORRECTIVE ACTION SHOLLD BE REGULATION OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRIOPRIATE DEFICIENCY) W 368 Continued From page 23 W 368 Review of N edication Administration Record (MAR) on A xril 25, 2008 at approximately 6:00 PM revealer a Physician's Order (POS) dated March 2008 Further review of the POS revealed that the cile t was prescribed Debrox 15ML"instill 3 drops one adaily each ear." It should be noted that Client # ?'s MAR revealed that she received her ear drop a us prescribed prior to the medication bservation on April 24, 2008. At the time of the survey, the facility failed to provide evid ence that the medication prescribed. by the physiclan for Client #2 was consistently given in con pliance with the physician's orders.

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	summaries to investigative : 2008 incident signature of ti Coordinator's of the investiç 2008 incident	the affurnment in the line of	log revealed investionementloned incide by regarding the Man of evidence the date and Management eview. Additionally, ammary for the Octo led to evidence the cent Management eview.	nts. The ch 25, and review		•			
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25, 2008 at Managemer Continued no documer by the facility #1's record; Assessment evidence the Retardation	I:2!9 PM I Care I View of led evic 's nurse evealed 'dated signatu 'rofess loted th te at th	ent #1's medical book I revealed a Health Plan dated April 14, 3 I the plan revealed the dence that it had beek E. Further review of the "Community & How 23, 2007 also four of the Qualified National (QMRP).  The assessment has bottom of the form and date,	2008. nere was en signed Client ome Life siled to Mental				
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